

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



<b>Centre name:</b>	Talbot Lodge Nursing Home
<b>Centre ID:</b>	OSV-0000182
<b>Centre address:</b>	Kinsealy Lane, Malahide, Co. Dublin.
<b>Telephone number:</b>	01 846 2115
<b>Email address:</b>	paulinec@talbotgroup.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Kinsealy Properties Limited
<b>Provider Nominee:</b>	Pauline Connor
<b>Lead inspector:</b>	Nuala Rafferty
<b>Support inspector(s):</b>	Jim Kee
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	107
<b>Number of vacancies on the date of inspection:</b>	4

## **About monitoring of compliance**

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
02 December 2015 06:00	02 December 2015 19:30
03 December 2015 07:00	03 December 2015 15:00

The table below sets out the outcomes that were inspected against on this inspection.

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 15: Food and Nutrition	Non Compliant - Major
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Major

**Summary of findings from this inspection**

This was an unannounced monitoring inspection by the Health Information and Quality Authority (the Authority). The purpose of the inspection was to follow up on matters arising from a monitoring inspection carried out on 2 July 2015 and to monitor progress on the actions required arising from that inspection. The inspection also considered information received by the Authority in the form of unsolicited receipt of information, notifications and other relevant information.

As part of the inspection, the inspectors met with residents, relatives and staff members observed practices and reviewed documentation such as policies and procedures, staff rosters, care plans, medical records and risk management processes.

As this inspection was specifically to follow up on actions arising from the last inspection all lines of enquiry were not reviewed under each outcome.

It was found that some progress was made by the provider in implementing the required improvements identified in the last inspection but some of the failures found at that time were again evident on this inspection. Risks associated with governance and management, standards of clinical care and supervision of practice, inconsistent replacement of staff and safeguarding were found.

Changes to the clinical management team within the centre included new person in charge who commenced in post within the previous two months and a new director of care services who commenced three weeks previously.

The person in charge was assessed through interview and was found to have satisfactory knowledge of their role and responsibilities and sufficient experience and knowledge as required by the legislation. The director of care services to replace the person in charge in the event of her absence was also assessed through interview and was also found to have sufficient experience and knowledge as required by the legislation.

Inspectors noted that since their commencement in post both the person in charge and director of care had initiated improvements to raise standards of care delivery within the centre. These included the appointment of two additional activity coordinators and establishment of a revised programme of activities and a staff training plan for 2016.

However, further improvements to clinical governance and standards of care being delivered to residents were found to be required including effective supervision and work systems, clinical assessment and care planning. Inadequate staffing levels impacted on the supervision of care and did not support the provision of a good standard of care which met the needs of individual residents.

Action plans had been progressed in relation to some outcomes but sufficient progress was not made to improve the care and welfare of residents to a significant degree. Risks associated with governance and management, standards of clinical care and supervision of practice, inconsistent replacement of staff and safeguarding were found. The provider and person in charge were requested to attend a meeting with the Authority to discuss the inspection findings and an improvement notice was issued.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 01: Statement of Purpose***

***There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

A written statement of purpose that broadly described the service and facilities in the centre was available and contained the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Some revisions were required from the last inspection to ensure completeness of the information in respect of the following:

- \*the size and function of all rooms,
- \*separate facilities for day care,
- \*arrangements for the management of the centre where the person in charge is absent,
- \*arrangements for consultation with, and participation of, residents in the operation of the designated centre.

**Judgment:**

Compliant

***Outcome 02: Governance and Management***

***The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Although a management structure was in place the roles and responsibilities of the management team were not clearly defined. Inspectors also found that the management systems in place were not effective enough to ensure that an appropriate and safe level of care was being delivered to residents.

Inspectors acknowledge that there were very recent changes to key personnel within the management team who at the time of this inspection had not had an opportunity to embed changes they proposed to make.

The senior management team at the time of this inspection consisted of; a Person in Charge who will also be the Provider Nominee on behalf of the entity; General Manager to whom the person in charge reports; two Director of Care Service Managers one of whom recently took up the position. Both report to the person in charge. The clinical nurse manager team report to a director of care. Other key personnel included Catering and Human Resource managers working across other sites within the broader organisation.

Actions which were found to be addressed included;

- A report on an annual review of the quality and safety of care delivered to residents in the centre undertaken in September 2015 was available.

- One additional care staff was rostered on Area A

Other actions were progressed but did not address the non compliance included;

- The system in place to monitor quality and safety of care and the quality of life of residents was not effective in that it did not identify improvements required to raise standards of care, as part of overall quality and safety improvements. Although some aspects of clinical risks were monitored, such as falls, pressure ulcers and nutrition. Critical analysis of the data collected to identify trends and implement measures to prevent or reduce recurrence was not found.

- Adequate staffing resources and appropriate skill mix to ensure the delivery of safe, suitable and sufficient care to residents was not in place. This is a recurrent finding. The provider's response to the action plan following the last inspection stated that 'a comprehensive external review of staffing levels skill mix and allocations would be completed by end of August 2015 and a plan to effect recommendations arising would be developed', 'contingency cover of one extra staff would be rostered for up to 12 hours daily as cover for unforeseen absences, increased nursing and healthcare staff hours on a weekly basis was approved and an ongoing recruitment process'.

Although all of these actions were partially progressed it was noted that the overall level of implementation was not sufficient to ensure the delivery of safe, suitable and sufficient care to residents.

It was found that the contingency cover was not in place and although the additional hours were approved there were not sufficient staff recruited to fill the hours on a daily basis. Agency cover although sought was not always available. Recruitment was ongoing but due to a variety of leave, ongoing staff turnover and the national nursing shortage, this was proving to be a big challenge. Information requested and provided following this inspection shows that although 7 nurses were appointed since the last inspection - 7 plus a clinical nurse manager had also resigned. This resulted in a net reduction to the level of nurse cover available within the centre. The information also identifies that a further 4 nurses are awaiting registration with the nursing board or completion of an approved adaptation programme. The latest expected date of completion for these programmes is end of January 2016. The turnover of healthcare assistants was also high with 24 appointed since the last inspection and 13 resignations.

It was also found that the recommendations of the external staffing review which the provider commissioned were not yet implemented such as; increasing nursing and healthcare assistant staffing levels; revision of rosters with introduction of some shorter hour shifts; improving social opportunities and activities for residents; improvement to level of staff supervision training and mentoring; active involvement of nursing staff in direct care provision.

Governance and management systems to provide a safe appropriate, consistent, standard of care were not fully established.

For example;

- systems in place to supervise staff and monitor the standard of care provided and ensure the full implementation of care plans and treatment regimes were not effective.

- on night duty one clinical nurse manager had responsibility for supporting and advising staff, managing both clinical and non clinical emergencies and oversight of the delivery of care to the whole centre. But this nurse manager also had to deliver direct care to between 20 and 27 residents and in practice would generally provide support and advice by phone to the other areas.

- communication within and between teams in each area was not supportive of consistent practice. it was found that staffs' understanding of their own role and/or other team members role differed. For example some nursing staff thought that the care staff made their own decision on the formation of teams to deliver direct care to residents. Some care staff said the clinical nurse manager on duty on area B allocated care staff to their teams, whilst others thought the senior carer allocated staff. Information about residents was not consistently shared with staff delivering care in a timely manner. A formal staff handover to update the oncoming team on each resident's condition took place at the beginning and end of a shift but there was no formal method of exchanging information on changes which occurred during the day.

- changes to work systems such as the closure of the internal laundry not been communicated well to staff and the resulting impact on workload had not been considered or evaluated by management.

- two new management positions had been created but the roles and responsibilities

were not fully evident. Inspectors were told that these were operational management roles to provide support and supervise care. But these managers were also found to be involved in broader, service wide managerial and administrative functions which necessitated their presence and time away from direct care supervision on the floor. For example, senior management meetings, inputs into advocacy development of activities, staff appraisal and training. Due to the nursing staff depletion on the first day of inspection, one manager assumed the role of the nurse/clinical nurse manager to accompany the general practitioner in the review of residents. It was found that the role of the clinical nurse managers urgently required to be reviewed and some responsibilities currently delegated to them should more appropriately lie with the new director of care services role, particularly the areas of staff rostering and replacement. The responsibility of the clinical nurse managers to develop, review and update all care plans for every resident was also found to be inappropriate. Effectively it was found that the entire nursing team have no responsibility or accountability in this fundamental nursing role which contributes significantly to the lack of in depth knowledge of nurses for residents in their care. A staff support structure was found to be urgently required to provide advice on clinical care assessment planning and delivery, to improve communication and provide team building to build staff morale.

Findings which are linked to this outcome are detailed under other outcomes in this report specifically under outcomes; 7, 8, 11, 15, 16 and 18.

Some of these areas were discussed with the person in charge directors of care services and general manager during and at close of inspection.

**Judgment:**

Non Compliant - Major

***Outcome 04: Suitable Person in Charge***

***The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The centre was managed by a suitably qualified and experienced nurse recently appointed to the role.

The person in charge was assessed through interview and throughout the inspection process and was found to have satisfactory knowledge of the roles and responsibilities and sufficient experience and knowledge under the legislation.



She understood the requirements of the service and discussed plans to bring the service into compliance

**Judgment:**

Compliant

***Outcome 06: Absence of the Person in charge***  
***The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Suitable arrangements were in place for periods of absence of the person in charge and the provider complied. The provider complied with his responsibilities to notify the Authority when a change occurred to both the person in charge and the nominated person to replace them.

The director of care services to replace the person in charge in the event of her absence was assessed through interview and during the inspection and was found to have sufficient experience and knowledge as required by the legislation

**Judgment:**

Compliant

***Outcome 07: Safeguarding and Safety***  
***Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Issues arising from the last inspection were found to be partially addressed but further improvements were required.

A review of the use of restraint showed that there was a reduction in the use of bed rails throughout the centre; however bed rails were still in place for some residents. It was found that appropriate assessments for this type of restraint were not being fully completed and there was no clear rationale for their use in some cases. Inspectors did note that there was a move towards changing the culture and promoting a restraint free environment with an increase in the use of alternative safety measures such as bed alarms, roll out mats and low-low beds. There was no evidence that the use of PRN (as required) psychotropic medication was unreasonably restrictive or unnecessarily implemented.

Measures to prevent and reduce the impact of behaviours that challenge on other residents and ensure residents safety through increased supervision on a 1:1 basis were in place for two residents on one area. But the overall management of residents with behaviours that challenge required improvement

Actions not addressed included;

Positive behaviour support plans to appropriately and consistently manage behaviours that challenge were not in place. Care plans which were in place related to underlying diagnosis of dementia that identified responsive behaviours such as resistance to personal care and increasing agitation. Assessments included blood screening and behaviour monitoring charts. But care plans did not identify or guide staff on possible triggers and measures to alleviate or manage the behaviour such as distraction techniques and other strategies to prevent escalation.

Inspectors learned that an intervention used to manage behaviours that challenge when intimate care was being provided represented a form of restrictive practice. Evidence that prior alternatives were tried, that this practice was assessed and deemed suitable or safe was not available. It was also noted that the use of the practice was not documented in any of the clinical documentation or records available and reviewed by inspectors.

There was an adult protection policy in place within the centre and staff spoken to by the inspectors confirmed that they had received training on elder abuse. There were reporting mechanisms in place to direct what staff should do in the event of a disclosure about actual, alleged or suspected abuse. Evidence that some staff were clear on the policy and procedures in place was found where the Authority was recently notified of a concern which was under investigation at the time of inspection. But it was found that all staff were not knowledgeable or consistent in recognising the possible signs and symptoms of abuse, responding to, managing and reporting them.

Inspectors noted bruising on the arms of a resident for whom a restrictive form of intervention was used. These bruises had not been reported to any member of the clinical nursing team; they were not identified or reported by either care assistants or nursing staff in order to initiate a preliminary investigation to ensure the safety of the resident and out rule possible abuse.

This failure to identify, investigate and notify signs and symptoms of abuse is a

recurrent finding on recent inspections.

This is also linked to findings in Outcome 18 in relation to staff training and supervision.

**Judgment:**

Non Compliant - Major

***Outcome 08: Health and Safety and Risk Management  
The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Actions arising from the last inspection were found to be partially addressed.

On review of fire training records inspectors found that staff were provided with regular updates on fire prevention and control. Records showed two training events since the last inspection were attended by up to 50 staff.

The records indicated the training included checking the fire panel; delegation of staff to investigate the location of fire and evacuation of residents.

But the records did not contain sufficient detail to determine if fire evacuation drills which simulated night time conditions took place in the centre.

Staff knowledge and implementation of best practice to ensure good infection control and prevention was found to have improved. However, improvements to risk management systems in place continue to be required. Falls reports were carried out in each area as part of the overall system for reviewing incidents and adverse events involving residents. But it was found that an analysis of these audits as part of an overarching risk review programme was not in place.

Arrangements for investigating and learning from serious incidents/adverse events required improvement. Inspectors looked at a sample report of falls for the month of November for two areas. It was noted that in the course of a four week period there were 18 falls. Seven falls related to two particular residents.

Although measures to manage the risks associated with responsive behaviours and recurrent falls for one resident through 1:1 supervision and provision of a falls mat alarm to the other resident were noted, evidence that identifiable trends and risks were being responsively appropriately and consistently addressed was not available.

Inspectors noted that of the 18 falls 7 occurred between 01:00- 06:00 and a further 7 between 08:00 - midday. Many were noted to occur in residents' bedrooms but some continue to occur in communal areas which were not always supervised. A further

concern related to the incidence of head lacerations and bruising to face as a consequence of these falls.

**Judgment:**

Non Compliant - Moderate

***Outcome 09: Medication Management***

***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

The actions arising from the last inspection were partially addressed in that medications were individually identified as being suitable for crushing where this was required by the prescriber.

In general medication prescribing and administration practice was found to be in line with professional best practice guidance. However the duration of the administration of medication was found to be extensively outside of the timeframes recommended for administration for medications prescribed to residents at specific times.

Inspectors observed that the duration of the medication 'round' adversely affected the ability of nurses to administer medication within the recommended timeframe for medication efficacy and safety. This was confirmed by nursing staff and clinical nurse managers.

For example, medications which were prescribed for administration at 07:00 hours were not being administered until up to 2.5 hours later.

There were ongoing effects of this throughout the day.

Administration of medications started at 07:00 by the night nursing staff who administered to those residents who were awake. Due to the complexity of residents needs, sleep disturbances, responsive behaviours and other factors, nurses tried to give residents their medications in a timely manner whilst also ensuring they are not affecting sleep, can give them with food where appropriate or recommended and at a time when the resident is more likely to agree to take them.

But due to the duration of the administration round, it was found that there were only 2-3 hours between each administration instead of the required four.

**Judgment:**

Non Compliant - Moderate

**Outcome 11: Health and Social Care Needs**

*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Access to medical and allied health professionals was available. Residents had access to a general practitioner (GP).

Evidence of access to allied health professionals was also found with documented visits, assessments and recommendations by occupational therapy, physiotherapy and psychology dental, optical and podiatry services. Access to palliative care specialists was available through the primary care and acute hospital services. A dietician consultancy service was recently contracted via a private nutrition products company

Although some aspects of care were found to have improved on this inspection it was noted that these improvements did not make a significant impact on the overall standard of care delivered to residents on an ongoing basis.

Some improvements were noted.

- a system was established to monitor the intake of residents identified as at risk of malnutrition and weights were also being monitored on a monthly or weekly basis as required.
- Residents at risk were being reviewed by a dietician.
- Pressure relieving mattress systems in use were on automatic settings or set at the correct level. All were noted to be in good working order. Repositioning regimes for identified residents were in place.

Actions required from the last inspection in respect of assessments implementation of care plans and review of care were not addressed.

Although a number of core risk assessment tools were used to evaluate clinical risks such as pressure sores and the risk of malnutrition, comprehensive continence and pain assessments were not undertaken.

Regulation 5 (3) states that each resident should have a care plan prepared based on a comprehensive assessment of their, personal, health and social care needs. However, it was found that care plans were not in place for all residents with active medical issues such as; dementia; constipation; responsive behaviours; skin lesions; delirium; sleep disturbances; restrictive practices and palliative care.

-where care plans were in place they did not contain enough detail to ensure they were effectively managing the health problem examples include; pressure area care; agitation; constipation; nutrition and personal care.

-although care plans were reviewed on a quarterly basis they were not all updated as needs changed as required by the regulations Where plans were reviewed the review did not include a determination of effectiveness to ensure improvement in the standard of care being delivered.

It was also noted that care plans were generic in nature, were not person centred and not always implemented.

Inspectors found that further improvements were still required to deliver a safe and suitable standard of care and to ensure the clinical care needs of all residents were fully met.

- The documentation of food and fluid intake was not consistent, contemporaneous or in enough detail to make it relevant for analysis

- Significant weight loss was noted for a sample number of five residents. Other findings relevant to nutrition management are referenced under outcome 15.

- Repositioning records for some residents' who required to be repositioned every 2-4 hours, were not maintained up to date and during a 12 hour period in some instances there were only two entries to reflect a positional change took place. It was also observed that where records were maintained the position recorded did not always accord with the position of the resident at that time.

- Recommendations by allied health professionals were not consistently implemented. Regular daily walks were not being facilitated for specific residents to improve muscle tone balance and maintain levels of independence. On review of documentation and in conversation with staff it was found that staff rarely had time to implement the recommendation and the residents usually only engaged in the exercise on a weekly basis with the physiotherapist.

- Frequency of wound assessments and dressings were not identified and were not reviewed on a regular or consistent basis in all cases. On review of documentation it was noted that several pressure ulcers had not been graded to enable an accurate determination of the depth of pressure ulcer and implement appropriate management.

-Recurrent findings related to lack of stimulation and residents social needs not being met are included under outcome 16

Overall it was found that the quality of clinical documentation, together with practices observed, did not provide evidence of a high standard of nursing care. Daily nursing progress notes were primarily summation and did not always refer to changes in health care plans or changes to treatments or recommendations made by clinicians.

Care plans, nursing progress notes and other supporting documentation were not appropriately linked to give a clear and accurate picture of residents' overall health status and management.

Insufficient clinical supervision and leadership coupled with changes to work systems and non replacement of core direct care staffing were found to contribute significantly to

the standard of care delivered to residents and are also referenced under outcomes 2, 7 and 18

**Judgment:**

Non Compliant - Major

***Outcome 12: Safe and Suitable Premises***

***The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

Actions arising from the previous inspection were being actioned during this visit.

The premises were found to be visually clean, tidy and uncluttered. Assistive equipment was in place and available for use and in good working order, service records were up to date and maintenance contracts were in place. Fire doors and stair wells were not obstructed and could be accessed freely in the event of an emergency.

Actions addressed included;

- improved access to the new wing in Area A via a new doorway in the dining room with faster and easier access to both ends of a very large extensive unit.
- Revision of layout in former three bedded rooms on Area A which have been reduced to twin rooms.
- Reduction of bed capacity in three twin rooms down to single on area B identified as not being of suitable size to ensure the privacy and dignity of residents was maintained at all times.
- The laundry facility has been closed and laundry services are now provided through an external company

One action remains outstanding where racking was not yet in place in sluice areas.

Maintenance work was ongoing throughout the centre. The centre was suitably decorated. Many of the bedrooms viewed by inspectors had been personalised with photos, pictures and other personal items. There was a functioning call bell system in place throughout the centre.

However risks associated with the location and safety of flooring in designated smoking

areas were found. Inspectors observed residents going out to smoke in the external 'hut'. It was a cold and wet day and the structure was found to be cold. There were steps at the entrance and these were wet and slippery. Although a grab rail was in place, the entrance and flooring in the smoking area were wet and found to pose a risk of falls to residents.

**Judgment:**

Substantially Compliant

***Outcome 15: Food and Nutrition***

***Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

This action was partially addressed. As referenced under outcome 11 improvements were made to the assessment and monitoring of residents with nutritional needs. Evidence of referral to relevant allied health professional including dietician or speech and language therapists was found and a system was established to monitor the intake of residents identified as at risk of malnutrition

But it was found that the system of recording intake was not consistent or detailed enough to ensure meaningful analysis of the information to improve health outcomes. Consistency of approach was found to be required and determination of portion sizes in order to be able to accurately assess intake when diaries refer to 'half/ quarter/ full' meal taken.

Other actions addressed included review of the menu by a dietician in October 2015 to ensure that menus were nutritionally balanced and suitable for the needs of residents.

However, the recommendations of the dietician to improve the menu by including all meals, snacks and food options available had not been implemented. Other recommendations of the dietician to offer alternatives for mid morning snacks such as soup, fruit or yoghurt or offering high calorie desserts to residents who had poor intake were not observed being implemented and food records reviewed did not indicate they were offered.

However there were recurrent findings in relation to the temperature of food provided to residents and the involvement of direct care staff in the preparation of some meals. It



was also noted that high numbers of residents continued to receive their meals in their own rooms and there were not sufficient staff to provide assistance or encourage residents to eat their meals and where residents refused meals it was unclear whether alternative options were offered or provided.

The system in place for serving meals at an appropriate temperature and in a timely manner had been reviewed. Staff brought a tray to those residents who remained in their bedrooms at meal times. But it was observed that the trays contained all three courses of the meal, i.e. soup, main course and dessert. This meant that for residents who ate slowly due to reduced dexterity, swallow impairment or reluctance to eat, food was becoming cold. Other issues negatively impacted on residents receiving hot meals. For example while staff assisted residents with toileting, it was observed that the meal was left sitting on the side table. Meals were left on side tables at the bedside for those residents who did not require assistance to eat. The residents were told their meal was there and in some instances assistance to sit more upright, bring the table closer to enable them access the meal was given, but this assistance was not provided in all cases. In one area, the inspector observed that where residents remained in their rooms and required full assistance to eat their meals, this was provided. But it was also observed that for some who were reluctant to eat or had disturbed sleep the night before and were sleeping at the meal time, staff did not have time to remain and encourage them to eat. This was of particular concern due to the profile of residents that included seven residents who were identified of being at risk of malnutrition, of whom five also had responsive behaviours that were challenging and four were known to have had recent and/or significant weight loss.

When food diaries were reviewed in the afternoon it was found that of the seven residents on food monitoring diaries; on two records no intake was recorded; on a total of five records no food intake was recorded. The remaining two records were not viewed by the inspector.

The inspector did observe that in the case of both residents whose diary did not have any entries both lunch trays returned to the kitchen untouched. There were three other residents observed who did not touch their food or who refused to eat either breakfast or lunch.

In one instance an inspector observed one resident trying to eat breakfast unaided in a sitting room. This person who had lost 10kgs of weight over a six month period since admission was assessed as being at risk of malnutrition and required full assistance at meals. The resident was given a breakfast of; porridge; toast; a boiled egg and tea on a tray at 09:10. The bowl of porridge was placed on his knee and the tray left on a side table in front. The resident ate a few spoons of porridge and then attempted to reach for the egg. The egg slipped from his hand and cracked onto the blanket. The resident then stopped trying to reach the remainder of his breakfast.

As there were no staff assisting the resident or supervising the area, the inspector sought out the clinical nurse manager to direct staff to give assistance to the resident.

Findings referenced under Outcomes 2 and 18 are also linked to this aspect of care.

**Judgment:**

Non Compliant - Major

***Outcome 16: Residents' Rights, Dignity and Consultation***

***Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.***

**Theme:**

Person-centred care and support

**Findings:**

Recurrent findings related to a lack of stimulation and activities relevant to residents past life and interests were again observed on this inspection.

Inspectors noted there were no restrictions to visitors and some residents were observed spending time with their relatives in sitting rooms or bedrooms. Some relatives visited on a frequent and daily basis. In conversation with them they told inspectors this was to provide support to staff and to ensure their loved ones safety by supervising them.

Although relatives were very complimentary of nursing, care assistants and other staff whom they said were good kind and respectful, they expressed concerns with some aspects of their experiences with the delivery of care and poor communication within the centre.

Concerns related to level of falls, action taken following falls and level of staffing to meet resident's care needs.

There was a lack of relevant recreational occupation and physical and/or sensory stimulation for residents throughout both days of inspection.

As observed previously on inspections, residents social, emotional and psychological needs were not being met through the delivery of a structured activities programme.

Although there was an activities programme in place. Only one activities coordinator was rostered to deliver this to 101 residents in four separate units. Mass was celebrated in the centre on the 1st day of the inspection and staff played old classic movie DVDs and background music CD's for residents who came to the sitting rooms. But for the vast majority it was observed that they spent long periods of time in their bedrooms and some remained in their rooms all the time. For others who were more mobile and appeared to be seeking stimulation, they were observed to spend considerable periods walking up and down the corridor.

Although in general staff seemed to be aware of the benefit and importance of stimulation for residents, the task orientated approach to care delivery took precedence over this aspect of social care needs. Some staff did turn on TV's, radio's or CD's for residents' who remained in their room. But inspectors observed there were still a high number of people for whom there was no stimulation or human interaction except when staff were providing assistance with an activity of daily living.

Although information was collated on residents past history and life interests, individual or group based activities relevant to them were not in place.

In conversation with staff they acknowledged that although a programme was available it was not fully delivered and did not meet the needs of residents who did not or could not participate in group activities. Staff recognised that residents were bored.

In conversation with the person in charge inspectors were told that a new activities programme was being devised and two additional staff were commencing to deliver it on 7 December. A draft programme was viewed and included activities with multi sensory objects, pottery, baking, relaxation therapy and arts and crafts.

However it was noted that individual sessions were not incorporated relevant to the resident profile although it is acknowledged that the programme was not fully sanctioned.

The new activities staff were met on the second day of inspection posting up the programme in readiness for commencement the following week.

**Judgment:**

Non Compliant - Moderate

***Outcome 18: Suitable Staffing***

***There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.***

**Theme:**

Workforce

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Action plan responses to actions arising under this outcome from the last inspection were not fully implemented or sustained by the provider.

The provider's action plan identified the following improvements would be implemented by 1 October 2015;

The provider committed to engage an external consultant to undertake a full external review of staffing levels and skill mix completed by end August 2015 whose recommendations would be carefully considered and action plan developed; 1 additional staff on night shift in Area A; an additional 96 nursing hours; an additional 84 healthcare assistant hours; 1 additional staff rostered to cover unforeseen absences daily; the appointment of clinical services manager to improve staff supervision.

On inspection it was found that;

-1 additional staff on night shift in Area A and the appointment of a clinical services manager had been implemented. It was also found that an additional 84 healthcare assistant hours were in place on Area C but were currently providing 1;1 supervision to 2 specific residents and did not deliver care as part of the team to the broad resident group.

-Although inspectors were told that an additional staff person was rostered to cover unforeseen absences for a period of time, this was no longer in place.

-The clinical services manager was appointed and there were now a team of two senior managers supporting the new clinical services manager (also known as the person in charge). But inspectors found that systems of direct care supervision were still not in place at this time.

-On review of the roster and comparison with actual staff over the course of the inspection and in comparison with previous rosters inspectors could not identify the additional 96 nursing hours. On the contrary inspectors found a decrease in the number of actual direct nursing care hours. In July 2015 there were three nurses and three clinical nurse managers' – total of 6 on the roster.

In August the external report on staffing levels stated there were four nurses and three clinical nurse managers' a total of 7 on rosters. However on this visit the total number of nurses and clinical nurse managers' rostered remained at July levels of 6 but due to non replacement of staff there were only 5 on duty.

-All of the recommendations of the external staffing review were not implemented and consideration of the environmental design and layout of the centre with challenges for staff such as; lengthy distances between communal rooms and bedrooms throughout the centre and supervision of large numbers of residents who spend considerable periods of time in bedrooms and was not included.

As previously referenced a good standard of safe and suitable care was not consistently delivered to residents. The Action plan responses to actions arising under this outcome from the last inspection were not fully implemented or sustained by the provider.

As previously referenced a good standard of safe and suitable care was not consistently delivered to residents. The inspection team found that the current profile of residents in the centre were frail elderly with a high level of complex needs. The age profile included 9 residents' between the ages of 95 and 102. In total 47% were between the ages of 85

and 95. 56% of all residents were assessed as being at high/ maximum dependency, meaning that they required the assistance of two staff with most or all of the activities of daily living. But the assessment tool in use to determine the residents' dependency only considered residents physical functional abilities and not cognitive function although 59% of the resident population also had a formal diagnosis of dementia, cognitive impairment or intellectual disabilities. It was also noted that 29% of residents exhibited responsive behaviours that could be challenging.

It was found at the time of this inspection, that the levels and skill mix of staff were not sufficient to meet the needs of residents.

This related primarily to a lack of qualified nursing staff and activities staff but it was also observed that healthcare staff were very busy and often times stretched to meet residents needs in a timely manner.

Non replacement of both nursing and healthcare assistant staff is a recurrent finding. Inspectors examined the planned and actual roster for the four units/areas in the centre. Day shifts were predominantly 12 hours from 08:00- 20:00 with 1 evening shift in area A from 17:00-23:00

Planned day shifts rostered;

Area A (43 Residents); 1 clinical nurse manager (CNM) and 1 staff nurse plus 7 healthcare assistants (HCAs) and 1 HCA on evening shift.

Area B (20 Residents) & C (27 Residents); 1 clinical nurse manager and 1 staff nurse plus 10 healthcare assistants on four days -11 on three days

Area D (21 Residents); 1 staff nurse plus 4 healthcare assistants.

Actual Staffing;

On the first day of inspection the staffing levels were depleted by Area D; reduced by 1 nurse. Area A reduced by 1 healthcare assistant.

On the second day of inspection Area A was again reduced by 1 healthcare assistant. This meant that the actual number of qualified nursing staff on duty was 5 for a total of 107 residents, with a nurse to resident staffing ratio of 1:22. This does not reflect recognised general guidance on staffing ratios for basic safe care.

Where the nurse complement rostered was not depleted and where there were no vacancies, the ratio remained above recommended guidance at 1;16. Although 7 healthcare assistants were allocated daily for Area A only 6 were routinely rostered and the provision of the 7th staff was dependent on agency, which it was found was not regularly provided.

On night duty the rostered staffing complement was 1 nurse and 1 healthcare assistant on three of the four areas with an additional healthcare assistant on area A. This represented a night nurse to resident ratio of 1;27. The lack of skilled and experienced nursing numbers contributed significantly to findings on inspection previously referenced under Outcomes 7;8;11 and 15 in that;

-Nurses were unable to monitor and supervise the standard of direct care practices to ensure care plans were fully implemented.

-Nurses were not involved in care plan development, assessment or review, only clinical

nurse managers engaged in this key nursing role.

-A clinical nurse manager or nurse was not always available to accompany the general practitioner to review residents and communicate with him on key clinical changes.

-Nurses were not available to provide support to care staff in managing residents suffering from delirium, confusion wandering or other high risks.

- Inadequate managerial and clinical support available for night staff

-Care plans were not always updated to reflect changes to residents' condition.

Records of care delivery such as repositioning charts and intake or output were not being recorded in a timely manner to ensure accuracy.

Non replacement of care staff also contributed to poor outcomes for residents. It was found that supervision of communal areas was not always in place with increased risks of falls and/or interactions between residents

Challenges of staff recruitment and retention were negatively impacting on managements' ability to fill the roster and there was a heavy reliance on agency and also on the current staff complement to take on additional shifts. Inspectors were told that some staff regularly worked in excess of 48 hours and sometimes as much as 60 hours per week to make up the shortfall. This was also reflected on the roster.

Work and communication systems that supported staff to deliver better care were not in place. Findings of the negative impact of poor work systems were recurrent on this occasion.

-Time available for nurses and clinical nurse managers to provide supervision and support was severely curtailed due to responsibility for staff replacement and extensive periods of time administering medication.

-Staff were not allocated to supervise or respond to residents seeking assistance. From approximately 08:15 to 09:30 on each area, it was observed that the nursing team administered medications and the healthcare assistant team served breakfast. It was noted that the healthcare staff were fully responsible for a lot of the breakfast preparation along with the service and provision of assistance to residents. This included both day and night staff as it was found that the night care assistants made breakfast for those residents who woke early and requested it. On one area up to 7 residents would regularly receive an early breakfast. This reduced the availability of staff to supervise residents and respond to requests for assistance. One resident was calling repeatedly to staff from 06:00. The night staff team gave this resident an early breakfast and although day staff did go to him, it was noted that they did so primarily to provide reassurance that they would return later.

-A key worker system whereby staff are allocated to small groups of residents for whose care they become accountable was not in place. This contributed to the lack of contemporaneous documentation of care delivery and reporting of key changes in resident's overall condition.

-Although it was noted that nursing staff were familiar with the residents on their respective units they did not have in depth knowledge of all of their needs, past history or current condition. Inspectors found that this was because nursing staff were not involved in the assessment of residents' needs, development or review of care plans. Also this was due in part to recent high staff turnover with new nursing personnel some completing induction and use of agency staff.

-Healthcare assistants were also broadly familiar with residents but key information such as recognising triggers for responsive behaviours were not known by all.  
-Communication between staff residents and relatives required to be improved. Inspectors observed staff had very little time to chat or listen to residents. Interactions although respectful were task orientated and time to communicate with persons with sensory and/or cognitive impairment or provide reassurance was very limited. Relatives also highlighted the need for better communication.

Updated training to improve staff knowledge relevant to the resident profile was found to be required. As identified under It was also found that they would benefit from updated training on areas inclusive of but not limited to safeguarding vulnerable adults, dementia; positive behavioural supports; identifying and managing delirium; communication; assessment planning and review of care plans and person centred care. Inspectors were shown a draft training plan by the recently appointed person in charge who had already identified some of the deficits noted by inspectors.

**Judgment:**  
Non Compliant - Major

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

### ***Report Compiled by:***

Nuala Rafferty  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

# Health Information and Quality Authority Regulation Directorate

## Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Talbot Lodge Nursing Home
<b>Centre ID:</b>	OSV-0000182
<b>Date of inspection:</b>	02/12/2015
<b>Date of response:</b>	15/01/2016

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### Outcome 02: Governance and Management

#### Theme:

Governance, Leadership and Management

#### The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Evidence that there were sufficient resources in terms of staffing levels and skill mix to provide safe sufficient and appropriate care to residents was not available.

#### 1. Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.



purpose.

**Please state the actions you have taken or are planning to take:**

- Develop and implement management processes to continuously monitor staff rosters based on resident dependency/occupancy to determine and ensure minimum staffing levels are on duty at all times.
- Additional Staff Nurse will be rostered on Night Duty- This additional nurse will be allocated to Area A and will allow the Clinical Nurse Manager on duty to offer support and advise to staff.
- In addition to the two Activity Instructors who commenced recently a fulltime Activities Coordinator has been appointed and will take up duty on 18/01/16.
- Continue existing recruitment campaign to achieve required complements.
- Rosters are now completed four to six weeks in advance. This facilitates forward planning and advance booking of agency staff when required.
- In consultation with Human Resources Department develop a strategy on retention of experienced staff.

Currently we are actively recruiting 5 Nursing Staff. 4 of these staff are in the process of completing Adaptation Programme and/or registration with NMBI.

Recruitment process for 2 additional nurses has commenced to fill the additional post approved for night duty.

The filling of 6 of the 7 positions is dependent on successful completion of Adaptation Programme and/or registration with NMBI. Every effort is being made to expedite these appointments. In the interim, we will book agency nursing to maintain staffing levels.

**Proposed Timescale:** 16/02/2016

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Changes to the structure of the organisation included new management roles. But the role, responsibilities and level of accountability and authority within the management team both clinical and non clinical were not clearly defined.

**2. Action Required:**

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**

•A review of the roles and responsibilities of the management team has commenced. The review involves clearly defining the responsibilities, level of accountability and authority within the management team.

•A review of the roles of Clinical Nurse Manager, Staff Nurse and Health Care Assistant will also be completed with a particular emphasis on responsibilities, supervision and organisation of work/allocation of duties.

•Job Specifications for all roles will be reflected in Job descriptions.

•Both reviews when completed will be clearly communicated to all staff and training for staff will be provided as required. Any changes arising from both reviews will be implemented.

**Proposed Timescale:** 16/02/2016

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Operational management systems in place did not effectively monitor care practices to ensure the delivery of safe consistent care to all residents.

**3. Action Required:**

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**

•To improve operational management systems, the roles and responsibilities of senior Director of Cares who support the Provider Nominee/Person In-Charge are under review to include Practice Development, Care Planning, Documentation, Continuous Training and Education, Policy Development and Operational Management.

•To embed new Clinical Management appointments, new systems processes, activity programs and complete training, all of which are necessary to make the improvements required in respect of actions contained in the inspection Report and to achieve compliance with the Improvement Notice, it was agreed that there will be no new admissions until the Chief Inspector is satisfied that the improvement have been made.

•To improve operational management the Provider Nominee/Person In-Charge will chair a monthly Management meeting which will be attended by heads of department, where by the following items will be discussed Practice Development, Quality, Risk and Safety Issues Risk, Complaints, Issues and HIQA Notifications and action plans. Hygiene and Infection Control and Recruitment and Retention and any other items that are deemed necessary.

•To progress robust communication within the Home following this Management Team

meeting, the Clinical Nurse Managers with the support from the PIC/Provider Nominee and Director of Care will have monthly team meetings at unit level to progress information sharing to ensure best practice within the teams.

- A full review of all Care Plans has commenced prioritizing those with nutritional, behavioural and wound management care needs. A new individualised person centred plan of care is being put in place for every resident to ensure that they receive the best quality of care and enhanced quality of life by having their needs appropriately assessed, planned and delivered in accordance with the residents needs and wishes.

- The care plans will be formally reviewed and evaluated in consultation with the resident and/or representative as indicated by the residents changing needs and/or circumstances, and no less frequently than at four-monthly intervals.

- A full review of all Schedule 5 Policies and Clinical Policies to inform best practice has commenced and will be prioritised, with full completion by 31/05/2016

- In addition to the Clinical Nurse Managers and Director of Care the Provider Nominee/Person In-Charge will maintain on-going oversight to provide guidance and support.

- In addition, the Provider Nominee/Person In-Charge will independently observe practice to ensure quality of care and quality of life for the residents in the centre is delivered in accordance with recommended best practice.

- Training and education will be provided to address any care practices identified through on-going observation of practices and audits.

- A training Programme for 2016 is in place, with priority given to refresher Elder Abuse Training, Moving and Handling training, Dementia Care and management of Challenging Behaviours. The programme commenced in January 2016.

- A Training Needs Analysis was completed following engagement with staff and a review of incidents and accidents for the period November- December 2015. The following has been identified -

- Review of work practices for staff with regard to safe moving and handling of residents. Provide refresher training.

- Review of management of Challenging Behaviour

- Review of work practices for staff with regard to nutritional needs and dining experiences for residents

- Staff to receive training in Dementia care, behaviours which challenge and respecting the rights and dignity of the person.

- Staff to receive training in the management of Falls Prevention and Wound management.

- Review of systems for reporting of all incidents/accidents.

- Complete review of system of documenting care of residents and referrals to AHP's.

- Ensure staff have achieved full competency in care delivery appropriate to their grade

- Improve communication between disciplines and care teams

•Outcomes from robust auditing of care delivery will be used to inform training needs for the future

**Proposed Timescale:** 16/02/2016

### **Outcome 07: Safeguarding and Safety**

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Some interventions in place to manage behaviours that challenge represented a form of restrictive practice.

Evidence that prior alternatives were tried, or that this practice was assessed and deemed suitable or safe was not available.

**4. Action Required:**

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

**Please state the actions you have taken or are planning to take:**

•The documentation to assess and manage the care of behaviours which challenge has been revised to ensure that the full range of practices are considered and that care delivered is assessed, deemed suitable and safe.

•A full review of all Care Plans has commenced prioritizing those requiring a positive behavioural plan of care to ensure that appropriate individualised care is documented and delivered in accordance with best practice and is person centred.

•Training in managing behaviours which challenge is commencing in January and is mandatory for all staff

**Proposed Timescale:** 16/02/2016

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

It was found that; appropriate assessments for the use of bedrails was not being fully completed and there was no clear rationale for their use in some cases.

**5. Action Required:**

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

**Please state the actions you have taken or are planning to take:**

- The documentation to assess and manage the care of residents who require Bedrails has been revised to use the Risk Balance Tool Assessment. Where Bedrails are used, care will be delivered in accordance with the assessed need and plan of care, and will be monitored in accordance with the National Restraint Policy for their Suitability and Safety.

- All residents who are currently using bedrails will be re-assessed using this tool and an individualised Care Plan will be developed for residents who are using bedrails.

**Proposed Timescale:** 16/02/2016

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

All staff were not knowledgeable or consistent in recognising the possible signs and symptoms of abuse, responding to, managing and reporting them.

**6. Action Required:**

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

**Please state the actions you have taken or are planning to take:**

- Refresher Training Sessions have been scheduled to commence in January 2016 on the Signs and Symptoms of Abuse, Responding to, Managing and Reporting all suspected or allegations of abuse. This training is mandatory for staff working in direct or indirect care.

The Provider Nominee/Person In-Charge will independently observe practice to ensure quality of care and quality of life for the residents in the centre is delivered in accordance with recommended best practice. Training needs identified will be incorporated into the training plan.

- Any deviations from best practice will be highlighted to staff concerned and appropriate measures put in place to ensure that incidence of practice that do not meet the required standards are eliminated.

- Following training a zero tolerance approach to poor practice which could contribute to residents being placed at risk of harm or abuse will be adopted. This will be supported by Key Performance Indicators and Performance Reporting on key service areas.

- Prior to return to work after a long-term absence staff will receive refresher training.

**Proposed Timescale:** 16/02/2016

## Outcome 08: Health and Safety and Risk Management

### Theme:

Safe care and support

### The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Systems in place to identify, record, investigate and learn from serious accidents and events were not effective.

### 7. Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

### Please state the actions you have taken or are planning to take:

- As part of the review of Schedule 5 Policies the Risk Management Policy will be revised to include provisions for the identification, recording, investigating and learning from serious incidents and adverse events.
- Training – Recognising and Reporting of Adverse Incidents - All Care Staff will be trained on the importance of being alert to adverse incidents and how to report such incidents in a timely manner.
- Fire Training – Fire evacuation drills that simulate night time conditions will be conducted and clearly documented.

### Risk Management Process

- Stage 1 - Reporting of Adverse Incidents. A Resident Incident Report Form has been implemented for the reporting of all adverse incidents. The staff member(s) involved or who become aware of an incident is responsible for reporting the incident. The incident must be reported immediately by the staff member to their line manager who is responsible for completing the Incident Report Form.
- Stage 2 - Review Process at Unit Level. All incident forms are reviewed by the Clinical Nurse Manager and Director of Care. Any actions arising are implemented at unit level to mitigate a similar occurrence happening and when completed with agreed actions this form is forwarded to the Provider Nominee/Person In-Charge for overall review.
- Stage 3 - Review by Person In-Charge. All incidents are reviewed by the Provider Nominee/Person In-Charge. The actions implemented to prevent a reoccurrence and the learning outcomes at individual, unit and Nursing Home level and how this learning is implemented are included in this review.
- Stage 4 – Management Team Input and Oversight. This review will identify the circumstances which led to the incident occurring. The responsible person for the management of the risk going forward will be decided by the Provider Nominee/Person

In-Charge. This will be addressed at monthly Management meeting chaired by the Provider Nominee/ Person in Charge which will be attended by heads of department, where by all learning from serious incidents or adverse events will be discussed and actioned. This learning will be communicated to all staff at the monthly team meetings.

Significant Risks - will be escalated through the line management structures to the Director of Care and/or Provider Nominee/Person in Charge, and where necessary from the Provider Nominee/Person in Charge to General Manager and Chief Executive Officer. Action will be taken to mitigate these risks, as they arise and the Risk Register updated accordingly.

Quality and Risk Committee – The Quality and Risk Committee will meet on a quarterly basis at which the risk register will be kept under review.

Advisory Board – An information report will be submitted to The Advisory Board on a quarterly basis.

**Proposed Timescale:** 16/02/2016

### **Outcome 09: Medication Management**

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Prescribed medicines were being administered outside the prescribed timeframe due to the length of time taken to complete medication administration rounds.

**8. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**

- The Medication Kardex will be revised to have the first medication administration at 08.00hrs to better reflect the needs of the resident and ensure best practice guidance is followed.
- A full review of Medication Prescriptions will be undertaken to ensure all medicinal products are administered in accordance with the directions of the prescriber and in accordance with any advice provided by pharmacist regarding the appropriate use of the product.
- Day Duty Nursing Complement – Recruitment on-going to achieve full complement of seven nurses on day duty.
- Night Duty Nursing Complement will be increased from four to five (1X CNM and 4 X Staff Nurses).

Currently we are actively recruiting 5 Nursing Staff. 4 of these staff are in the process of completing Adaptation Programme and/or registration with NMBI.

Recruitment process for 2 additional nurses has commenced to fill the additional post approved for night duty.

The filling of 6 of the 7 positions is dependent on successful completion of Adaptation Programme and/or registration with NMBI. Every effort is being made to expedite these appointments. In the interim, when available agency nursing will be used to maintain staffing levels.

**Proposed Timescale:** 16/02/2016

### **Outcome 11: Health and Social Care Needs**

#### **Theme:**

Effective care and support

#### **The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The full care needs of all residents were not being met and suitable safe and sufficient care was not being provided.

#### **9. Action Required:**

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

#### **Please state the actions you have taken or are planning to take:**

- To improve operational management systems, the roles and responsibilities of senior Director of Cares who support the Provider Nominee/Person In-Charge are under review to include Practice Development, Care Planning, Documentation, Continuous Training and Education, Policy Development and Operational Management.

- A full review of all Care Plans has commenced prioritizing those with nutritional, behavioural and wound management care needs. A new individualised person centred plan of care is being put in place for every resident to ensure that they receive the best quality of care and enhanced quality of life by having their needs appropriately assessed, planned and delivered in accordance with the residents needs and wishes.

- Implementation of "Key Worker" system for both nursing and care staff, ensuring there is clarity in relation to responsibility for resident care.

- Following a Comprehensive Assessment of Needs, timely referral and review will be conducted by the appropriate AHP and resident's plan of care will be revised to incorporate all recommendations.

- The care plans will be formally reviewed and evaluated in consultation with the resident and/or representative as indicated by the residents changing needs and/or



circumstances, and no less frequently than at four-monthly intervals.

- In addition to the Clinical Nurse Managers, the Provider Nominee/Person In-Charge will maintain on-going oversight to provide guidance and support.

- The Provider Nominee/Person In-Charge will keep under review and monitor the quality of care and quality of life of residents in the centre on a weekly basis to ensure appropriate supports are in place.

- A Clinical Audit Programme for 2016 outlining the Clinical Audits and the frequency with which they will be conducted is currently being devised. Findings from these Audits will be used to improve Standards of Care.

- Following staff training, competency assessments of knowledge and skills will be conducted to ensure staff are adequately equipped to deliver quality care in accordance with resident's assessed needs and plan of care.

**Proposed Timescale:** 16/02/2016

**Theme:**

Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Residents did not have comprehensive nursing assessments to identify their personal, health and social care needs as detailed in the report.

**10. Action Required:**

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

**Please state the actions you have taken or are planning to take:**

A full review of all Care Plans using a comprehensive assessment tool has commenced prioritising those with nutritional, behavioural and wound management care needs. A new individualised person centred plan of care is being put in place for every resident to ensure that they receive the best quality of care and enhanced quality of life by having their needs appropriately assessed, planned and delivered in accordance with the residents needs and wishes.

**Proposed Timescale:** 16/02/2016

**Theme:**

Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Care plans were generic in nature and lacked sufficient detail to direct staff to provide

consistent care.

Residents did not have care plans for existing medical conditions

Care plans were not amended in light of residents changing needs

Care plans for behaviours that challenge did not identify triggers in order to prevent escalation of behaviours.

**11. Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

**Please state the actions you have taken or are planning to take:**

- A full review of all Care Plans has commenced prioritising those with nutritional, behavioural and wound management care needs. A new individualised person centred plan of care is being put in place for every resident to ensure that they receive the best quality of care and enhanced quality of life by having their needs appropriately assessed, planned and delivered in accordance with the residents needs and wishes.

- All residents who by their assessed need require a Positive Behavioural Support Care Plan, will have their needs assessed and a care plan developed which clearly outline triggers in order to prevent escalation of behaviours.

- Implementation of "Key Worker" system for nursing staff ensuring there is clarity in relation to responsibility for resident care.

**Proposed Timescale:** 16/02/2016

**Theme:**

Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There was no documentary evidence that the quarterly review of care plans included an evaluation to determine the effectiveness of the interventions in the plan.

**12. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

**Please state the actions you have taken or are planning to take:**

- Following a full review of all Care Plans and transfer to the new care planning documentation, all care plans will be evaluated to determine the effectiveness of the interventions in the plan as indicated by the residents changing needs and circumstances. Reviews will take place no less frequently than at four monthly intervals in consultation with the resident concerned and where appropriate the resident's family.

- A recognised Computerised Care Planning Systems is being implemented with

mandatory training for staff commencing week being 11/1/2016.

- Implementation of "Key Worker" system for nursing staff ensuring there is clarity in relation to responsibility for resident care reviews.

**Proposed Timescale:** 16/02/2016

**Theme:**

Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

A high standard of evidence based nursing care was not being delivered to all residents to fully meet their personal social and healthcare care needs as detailed in the report.

**13. Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

**Please state the actions you have taken or are planning to take:**

- Following a Comprehensive Assessment of Needs, timely referral to Medical and Allied Health Professionals for review will be carried out by the allocated nurse and the resident's plan of care will be revised to incorporate all recommendations following this review in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

**Proposed Timescale:** 16/02/2016

**Outcome 12: Safe and Suitable Premises**

**Theme:**

Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Adaptations to external smoking facilities to minimise risk of falls during wet weather and improve the level of heating were required.

Appropriate racking were not available in all sluice facilities.

**14. Action Required:**

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

**Please state the actions you have taken or are planning to take:**

- The external smoking facilities will be upgraded to minimise risk of falls during wet

weather.

- Heating will be installed in the external smoking facilities.
- Where required sluice facilities will be fitted with appropriate racking.

**Proposed Timescale:** 16/02/2016

## **Outcome 15: Food and Nutrition**

### **Theme:**

Person-centred care and support

### **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The nutritional needs of all residents were not being met and some had experienced significant weight loss.

### **15. Action Required:**

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

### **Please state the actions you have taken or are planning to take:**

- A full review of all Care Plans has commenced prioritizing those with nutritional care needs. A new individualised person centred plan of care is being put in place for every resident to ensure that they receive the best quality of care and enhanced quality of life by having their needs appropriately assessed, planned and delivered in accordance with the residents needs and wishes
- All residents who require referral or re-referral to dietician will be given priority and resident's plan of care will be revised to incorporate all recommendations.
- All recommendations will be fully communicated to both the care and catering teams to ensure the dietary needs of residents as prescribed by health care or dietetic staff is provided in accordance with the individual care plan of the resident concerned.
- Catering Manager will be involved in all dietary and nutritional needs of the residents.
- Food and fluid charts have been revised to adequately capture the calorie and fluid intake of residents at risk of malnutrition or dehydration in order to appropriately assess, plan and deliver quality care.
- Currently dietetic services are provided by arrangement with external companies. The appointment of a Consultant Nutritionist/Dietitian on a sessional basis is in progress with an expected commencement date in February 2016

**Proposed Timescale:** 16/01/2016

**Theme:**

Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Adequate staff were not available to provide assistance, supervision or encouragement with meals to all residents who required it.

**16. Action Required:**

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

**Please state the actions you have taken or are planning to take:**

•A review of systems and work practices was completed in consultation with the catering team to ensure assistance, supervision or encouragement with meals to all residents who required it is provided.

•Work systems and practices are under review and changes are being made to enhance the dining experience for residents from actions drawn up following observation of practice using the Workplace Cultural Critical Analysis Tool (WCCAT).

**Proposed Timescale:** 16/01/2016

**Outcome 16: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Residents were not supported to participate in activities in accordance with their capacities. Group and individual activities that are meaningful and reflect residents past interests or lifestyles and activities specific to residents with cognitive impairments and/or with limited or no mobility were not evident.

**17. Action Required:**

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

**Please state the actions you have taken or are planning to take:**

•The programme of activities developed by the 2 Activity Instructors who recently commenced in Talbot Lodge will be kept under review to ensure that it is consistent with the interests of the residents.

•Resident activities have commenced since the 7th December with full schedule made available to resident on each units Resident notice boards.

•In addition to the 2 Activity Instructors an Activities Coordinator has been appointed

and will take up duty on 18/01/16.

- A comprehensive programme of activities to include individual, interactive and group activities that meets the needs of all residents will be prioritised and developed within one month of the Activities Coordinator taking up duty. This will include activities specific to residents with cognitive impairment and/or with limited or no mobility.
- The implementation of a "Key Worker" system for nurses and care staff will be utilised to ensure the wishes, likes and dislikes are captured and incorporated in an individualized person centred Activity and Social Plan of care which will meet the specific needs of the individual resident.

**Proposed Timescale:** 16/02/2016

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Care practices did not respect residents' rights to full choice in all aspects of daily life.

**18. Action Required:**

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

**Please state the actions you have taken or are planning to take:**

- A full review of all Care Plans has commenced prioritizing those with nutritional care needs. A new individualised person centred plan of care is being put in place for every resident to ensure that they receive the best quality of care and enhanced quality of life by having their needs appropriately assessed, planned and delivered in accordance with the residents needs and wishes.
- A Training Needs Analysis was completed following engagement with staff and a review of incidents and accidents for the period November- December 2015. The following has been identified -
  - Review of work practices for staff with regard to safe moving and handling of residents. Provide refresher training.
  - Review of management of Challenging Behaviour
  - Review of work practices for staff with regard to nutritional needs and dining experience for residents
  - Staff to receive training in Dementia care, behaviours which challenge and respecting the rights and dignity of the person.
  - Staff to receive training in the management of Falls Prevention and Wound Management.
  - Review of systems for reporting of all incidents/accidents.
  - Review of system of documenting care of residents and referrals to Medical and AHP's.
  - Ensure staff have achieved full competency in care delivery appropriate to their

position.

- Improve communication between disciplines and care teams
- Robust auditing of care delivery.
- Conduct Observations of Practice using the Workplace Cultural Critical Analysis Tool (WCCAT) and thereafter develop action plans to improve practice.
  
- SAGE (Support and Advocacy Service for Older People) who commenced providing a service to residents in Talbot Lodge in October 2015 will be invited to meet residents and their families to ensure Residents' Rights are protected and appropriate opportunities for communication are in place to meet the residents and their family's needs.
  
- Resident Committee meetings will take place on the 2nd Wednesday of every month and are independently facilitated by SAGE (Support and Advocacy Services for Older Person). With minutes made available to residents and Families.
  
- Quarterly Resident Newsletter will be introduced so that both resident and family members are kept informed of the units activities. 25/04/2016

**Proposed Timescale:** 16/02/2016

### **Outcome 18: Suitable Staffing**

#### **Theme:**

Workforce

#### **The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

- \* The number and skill mix of staff was not sufficient to meet the assessed needs of residents and did not take account of the size and layout of the centre.
  
- \* The number of nursing staff on duty providing direct care to residents were not sufficient to ensure a safe standard of suitable care was delivered.

#### **19. Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

#### **Please state the actions you have taken or are planning to take:**

- The nursing complement will be revised as follows – in addition to seven nursing staff on day duty the following will also be in place -  
Clinical Services Manager (Monday – Friday),  
Director of Care (Monday - Friday)  
Director of Care (Monday – Sunday)
  
- The night duty complement of Nursing Staff will be increased from four to five (1X CNM and 4 X Staff Nurses)

•The complement of Social Care/Activity Staff will be increased to three.

•Develop and implement management processes to continuously monitor staff rosters based on resident dependency/occupancy to determine and ensure minimum staffing levels are on duty at all times.

Currently we are actively recruiting 5 Nursing Staff. 4 of these staff are in the process of completing Adaptation Programme and/or registration with NMBI.

Recruitment process for 2 additional nurses has commenced to fill the additional post approved for night duty.

The filling of 6 of the 7 positions is dependent on successful completion of Adaptation Programme and/or registration with NMBI. Every effort is being made to expedite these appointments. In the interim, when available agency nursing will be used to maintain staffing levels.

**Proposed Timescale:** 16/02/2016

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Staff were not appropriately supervised to ensure that a good standard of care was delivered, which met residents needs in accordance with their care plan.

**20. Action Required:**

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**

•To improve operational management systems, the roles and responsibilities of senior Director of Cares who support the Provider Nominee/Person In-Charge are under review to include Practice Development, Care Planning, Documentation, Continuous Training and Education, Policy Development and Operational Management.

•A review of the roles of Clinical Nurse Manager, Staff Nurse and Health Care Assistant will also be completed with a particular emphasis on responsibilities, supervision and organisation of work/allocation of duties.

•Job Specifications for all roles will be reflected in Job descriptions.

•Both reviews when completed will be clearly communicated to all staff and training for staff will be provided as required. Any changes arising from both reviews will be implemented. .

•A Training Needs Analysis was completed following engagement with staff and a review of incidents and accidents for the period November- December 2015. A training



Programme for 2016 has been put in place, with priority given to refresher Elder Abuse Training, Moving and Handling training, Dementia Care, management of Challenging Behaviours and Incident reporting and management The programme commenced in January 2016.

**Proposed Timescale:** 16/02/2016